Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2013

This Form is Open to Public

Pensio	on Benefit Guaranty Corporation					Inspection	
Part I	Annual Report Identi						
For cale	ndar plan year 2013 or fiscal pla			and ending 12/31	/2013		
A This	return/report is for:	X a multiemployer plan;	a multiple	e-employer plan; or			
		a single-employer plan;	a DFE (s	specify)			
R This	return/report is:	the first return/report;	the final	return/report;			
	ctarrir oport is.	an amended return/report;		lan year return/report (less	than 12 m	onths).	
C If the	plan is a collectively-bargained	plan, check here				. > 🔀	
D Chec	k box if filing under:	X Form 5558;	automati	c extension;	th	e DFVC program;	
		special extension (enter desc	cription)				
Part		ation—enter all requested information	tion		1		
	ne of plan PPLEMENTAL SICKNESS BEN	NEFIT PLAN COVERING RAILROA	AD YARDMASTERS		1b	Three-digit plan number (PN) ▶	507
1112 00	TT EEMENTAL GIGITALOG BET	VETTI E III OOVERIII O IVIIERO	ID TARBIMACTERS		1c	Effective date of pla	an
30 Dis-					26	01/01/1979	4:
	a sponsor's name and address;	include room or suite number (empl	loyer, if for a single-	-employer plan)	2b	Employer Identifica Number (EIN) 52-1036399	tion
					2c	Sponsor's telephon number	
	STREET NW SUITE 500				24	202-862-7200 Business code (see	
WASHIN	IGTON, DC 20036				24	instructions) 482110	
Caution	: A penalty for the late or inco	omplete filing of this return/report	t will be assessed	unless reasonable cause	is establi	shed.	
		nalties set forth in the instructions, I the electronic version of this return					
SIGN HERE	Filed with authorized/valid elec	tronic signature.	10/15/2014	A. K. GRADIA			
	Signature of plan administra	ator	Date	Enter name of individual	signing as	plan administrator	
SIGN HERE							
HEKE	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor
SIGN HERE							
	Signature of DFE		Date	Enter name of individual	signing as	DFE	
Preparei	's name (including firm name, if	f applicable) and address; include ro	oom or suite numbe		Preparer's optional)	telephone number	

	Form 5500 (2013)	P	age 2							
3a		Same as Pi		onsor	· Addre	ess		3c /		strator's EIN strator's telephone r
4 a	If the name and/or EIN of the plan sponsor has changed since the last return/reEIN and the plan number from the last return/report: Sponsor's name	report filed	for this	s plar	n, ente	r the na	me,	4b 4c		
5	Total number of participants at the beginning of the plan year							5		196
6 a	Number of participants as of the end of the plan year (welfare plans complete of Active participants							6a		195-
b	Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits							6b		
d e	Subtotal. Add lines 6a , 6b , and 6c Deceased participants whose beneficiaries are receiving or are entitled to receiving or an entitled to receive the control of the control o							6c		1954
f g h	Total. Add lines 6d and 6e . Number of participants with account balances as of the end of the plan year (o complete this item)	only define	d contr	ibutic	on plar	าร		6g 6g	J	(
7	Enter the total number of employers obligated to contribute to the plan (only m							7		19
b	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature codes 4F	es from the	List of	Plan	Chara	acteristic	cs Codes	s in th	e instru	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor	9b Plan (1) (2) (3) (4)	×	In: Co Tr Ge	surand ode se rust eneral	ce ection 4° assets	12(e)(3) i of the sp	insura	ince co	
	Check all applicable boxes in 10a and 10b to indicate which schedules are attace. Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		d, whereral Sc		ules H (I (_ A ((Financ Financi (Insurar	ial Informal Informace Informace Provides	nation nation matio	i) – Smal n)	ll Plan)

(4)

(5)

(6)

(3)

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)).					
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and en	ding 12	2/31/2013			
A Name of plan THE SUPPLEMENTAL SI	CKNESS BEN	EFIT PLAN COVERING RAILRO	OAD YARDMASTERS	B Three	e-digit number (P	P(N) ▶	507		
C Plan sponsor's name a NATIONAL CARRIERS' C				D Emplo 52-103	-	cation Number (EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca		,							
TRUSTMARK INSURAN	JE COMPANY								
ALV EINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year		
(b) EIN	code	identification number	persons covered a policy or contract		(f)) From	(g) To		
36-0792925	61425	BTL 9000	19	54	01/01/20	013	12/31/2013		
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.									
(a) Total amount of commissions paid (b) Total amount of fees paid									
3 Persons receiving com	missions and	ees. (Complete as many entries	s as needed to report all	persons).					
	(a) Name :	and address of the agent, broker	, or other person to who	m commiss	ions or fees	s were paid			
(la) Amount of color or	. d b = = =	Fe	es and other commissio	ns paid					
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose	Э		(e) Organization code		
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	ions or fees	s were paid			
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid					
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code		

Schedule A (Form 5500)	2013	Page 2 - 1	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
(4)	and and address of the agent, stone	.,	
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / tinodit	(a) 1 dipose	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(O) / timodine	(a) 1 diposes	0000
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
	_		
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(o) / unoun	(4)	3345
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid
		Fees and other commissions paid	() 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	(1)	(2)	
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid
(h) Amount of sales and har-		Fees and other commissions paid	(2) Omanination
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
	, ,	, , ,	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	- (1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
					7 - (5)	
	£	(5) Total deductions.			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Page	4
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Pá	art I	If more than one contract covers the same grinformation may be combined for reporting puthe entire group of such individual contracts of	oup of employees of the surposes if such contracts with each carrier may be t	are experience	ce-rated as a unit. Wher	e contracts	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	c	Vision	(Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemple	oyment I	Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		Indemnity contract
	m	Other (specify)	- -	_	•		
	ı						
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)		1027039	
		(2) Increase (decrease) in amount due but unpaid		9a(2)		-2514	
		(3) Increase (decrease) in unearned premium res	serve	9a(3)		318211	
		(4) Earned ((1) + (2) - (3))				9a(4)	706314
	b	Benefit charges (1) Claims paid		• • •		640975	
		(2) Increase (decrease) in claim reserves				-99191	
		(3) Incurred claims (add (1) and (2))				9b(3)	541784
	_	(4) Claims charged			<u></u>	9b(4)	
	С	Remainder of premium: (1) Retention charges (c	•	0c(1)(A)			
		(A) Commissions		9c(1)(A) 9c(1)(B)			
		(B) Administrative service or other fees (C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		2 (4)(5)			
		(E) Taxes		0 (4)(5)		21688	
		(F) Charges for risks or other contingencies.		0 (4)(5)		10245	
		(G) Other retention charges		- (1)(-)		132596	
		(H) Total retention				9c(1)(H)	164529
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	_	_	_	9d(1)	
		(2) Claim reserves				9d(2)	175112
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e	308023
10	No	nexperience-rated contracts:			F		
	а	Total premiums or subscription charges paid to o	arrier			10a	
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than rep	, ,		•	10b	
	Sp	pecify nature of costs					

Part IV	Provision of Information			
11 Dic	the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

¹² If the answer to line 11 is "Yes," specify the information not provided.

Form **5500**

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of employer/plan sponsor

MATTHEW B DUBNANSKY, CPA

500 E PRATT ST STE 525

Signature of DFE

SIGN HERE

TMDG, LLC.

BALTIMORE

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2013

This Form Is Open to Public Inspection

	port Identification			
For the calendar plan year	2013 or fiscal plan ye	ear beginning	and	ending
A This return/report is for:	(1) X a multiemple	oyer plan;	(3) a r	nultiple-employer plan; or
	(2) a single-em	ployer plan;	(4) a D	FE (specify)
				
B This return/report is:	(1) the first retu		``	final return/report;
• If the relation is 10 or		return/report;	(4) a st	nort plan year return/report (less than 12 months).
		check here		······ <u>X</u>
D Check box if filing under:	X Form 5558;		aut	omatic extension; the DFVC program;
		nsion (enter description)		
Part II Basic Plan	Information - en	ter all requested information		
1 a Name of plan THE SUPPLEMENTAL RAILROAD YARDMAST	SICKNESS BENE			1b Three-digit plan number (PN) ► 507 1c Effective date of plan
2 a Plan sponsor's name and add	dress, including room or suite	number (employer, if for single-em	nolover plan)	01/01/1979 2b Employer Identification Number (EIN)
	, ,	(employer, it for strigte cit	proyer plany	52-1036399
				2c Sponsor's telephone number
				202-862-7200
				202-802-7200 2d Business code (see instructions)
				482110
NAMITONIA GARRIERO				
NATIONAL CARRIERS 1901 L STREET, NW WASHINGTON, DC 200	SUITE 500	COMMITTEE		
Caution: A penalty for the lat	e or incomplete filing o	of this return/report will be a	ssessed unless reason	able cause is established
under penalties of perjury and other p well as the electronic version of this re	enalties set forth in the instruction to the best of t	uctions, I declare that I have examing fing knowledge and belief, it is true	ned this return/report, including e, correct, and complete.	g accompanying schedules, statements and attachments, as
SIGN HERE Q. K. J.	afra	10/10/14	A. K. GRADIA	
Signature of plan adminis	trator	Date /	Enter name of individual si	gning as plan administrator
SIGN HERE				

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

21202-3178

Date

Date

Preparer's name (including firm name, if applicable) and address; including room or suite number. (optional)

MD

Form **5500** (2013) **v.130118**

Preparer's telephone number (optional)

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form	5500	(2013)

Page 2

4 If the name and/or EIN of the plan soonsor has changed since the last return/report filed for this plan, enter the name. EIN and the plan number from the last return/report: 3 Speriors name 5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year (verlare plans complete only lines 6a, 6b, 6c, and 6d) a Active participants. 6 A 1954 6 Retired or separated participants receiving benefits c Other retired or separated participants receiving benefits. 6 C C C C C C C C C C C C C C C C C C	3 a Plan administrator's name and address X Same as Plan Sponsor Name Same as	Plan Sponsor Address	3b Administrato	r's EIN	· · · · · · · · · · · · · · · · · · ·
a Sponsor's name 15 Total number of participants at the beginning of the plan year 16 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d) 18 Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d) 28 Active participants as a of the end of the plan year (welfare plans complete only lines 6a, 6b, and 6d) 29 A Plan total Add lines 6a, 6b, and 6c 30 Subtotal. Add lines 6a, 6b, and 6c 40 Subtotal. Add lines 6a, 6b, and 6c 41 Total. Add lines 6a, 6b, and 6c 41 Total. Add lines 6d and 6e 42 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 45 Reter the total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 46 Participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested. 5 If the plan provides pension benefits, enter the applicable pension feature codes from the list of Plan Characteristic Codes in the instructions: 47 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 19 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 48 If the plan provides pension benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: 49 Paralon Schedules 7 Trust 40 General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) 5 Demonstrated center the number attached. (See instructions) 6 Demonstrated center the number attached. (See instructions) 6 Demonstrated center the number attached. (See instructions) 7 Trust 6 Demonstrated center the plan informatio			3c Administrato	r's telep	phone number
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d) a Active participants. 6 a 1954 b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits. 6 b c Other retired or separated participants entitled to future benefits. 6 c d Subtotal. Add lines 6a, 6b, and 6c 6 d 1954 6 f f Total. Add lines 6d and 6e 6 f g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 6 h Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 7	d Sponsor's name				4c PN
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f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 6h 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 19 8 a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 4F 9 a Plan funding arrangement (check all that apply) (1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules 10 R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) S (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)	d Subtotal. Add lines 6a, 6b, and 6c			6 d	1954
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item). 7 19 8 a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 4F	• Deceased participants whose beneficiaries are receiving or are entitled to	receive benefits		6 e	
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Department of the Treasury Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

For Privacy Act and Paperwork Reduction Act Notice, see instructions. Information about Form 5558 and its instructions is at www.irs.gov/form5558.

OMB No. 1545-0212

File With IRS Only

MM DD	art	I Identification					
NATIONAL CARRIERS' CONFERENCE COMMITTEE Number, street, and room or suite number (17 a P.O. box, see instructions) 1901 L STREET, NW, SUITE 500 City or town, stale, and ZiP code WASHINGTON, DC 20036 THE SUPPLEMENTAL SICKNESS BENEFIT PLAN COVERING 507 12 31 Part III Extension of Time To File Form 5500 Series, and/or Form 8955-SSA Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above. I request an extension of time until		Name of filer, plan administrator, or plan sponsor (see instructions)	Employer identification number (EIN) (9 digits				
1901 L STREET, NW, SUITE 500 Social security number (SSN) (9 digits XXX-XX-XXXXX) WASHINGTON, DC 20036 Plan name Plan number Plan number MM DD		NATIONAL CARRIERS' CONFERENCE COMMITTEE	X XX-XXXXXXX	XX-XXXXXXXXX			
Social security number (SSN) (9 digits XXX-XXX-XXXXX) WASHINGTON, DC 20036 Plan name Plan number Plan number MM DD	1	Number, street, and room or suite number (if a P.O. box, see instructions)					
Plan name Plan number Plan number Plan number Plan number Plan number MM DD 1 THE SUPPLEMENTAL SICKNESS BENEFIT PLAN COVERING 507 12 31 Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA 1 Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above. 2 I request an extension of time until 10/15/2014 to file Form 5500 series (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 5500 series. 3 I request an extension of time until to file Form 8955-SSA (see instructions). Note. A signature IS NOT required if you are requesting an extension to file Form 8955-SSA. The application is automatically approved to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on line 2 and (above) is not later than the 15th day of the third month after the normal due date. Part III Extension of Time To File Form 5330 (see instructions) 4 I request an extension of time until to file Form 5330. a Enter the Code section(s) imposing the tax. b Enter the payment amount attached c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date. c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date.		1901 L STREET, NW, SUITE 500	_ > 52-103	<u> </u>			
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